

9231

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville Chestertown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle James Last Bond				4. DATE OF DEATH Month August Day 1 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1879	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John m. Bond				14. MOTHER'S MAIDEN NAME Elizabeth James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital records Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 33/17 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial Hypertension DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 1/2 hours 40 or 50 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/31/ 19 60 , to 8/1/ 19 60 , that I last saw the deceased alive on 8/1 19 60 , and that death occurred at 2:00 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED 8/1/60							
ACTUAL SIGNATURE Robert W. Farr M.D.				PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/60		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert J. McCree, Jr., Wilmington, Dela				24a. REC'D BY REGISTRAR DATE 8/1/60		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9232

CERTIFICATE OF DEATH

Reg. Dist. No.

09206

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.				d. STREET ADDRESS Quaker Neck Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Carl N. Middle Bordley Last				4. DATE OF DEATH Month Aug. Day 31 Year 1960			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1890		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant (retired)		10b. KIND OF BUSINESS OR INDUSTRY Retail Clothing		11. BIRTHPLACE (State or foreign country) Chestertown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Bordley				14. MOTHER'S MAIDEN NAME Grace Kemp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-32-6981		INFORMANT Address Mrs. Ruth B. Bordley, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible Bronchogenic Carcinoma							INTERVAL BETWEEN ONSET AND DEATH 12 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/15 , 19 60 , to 8/31 , 19 60 , that I last saw the deceased alive on 8/31 , 19 60 , and that death occurred at 8/31 , 19 60 , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert W. Farr M.D.				ADDRESS (Street, city or town, state) Chestertown Md 8/31/60 DATE SIGNED			
PHYSICIAN'S NAME (Type) Robert W. Farr				Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3/60		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) Fairlee Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR SEP 6 60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

102508

CERTIFICATE OF DEATH

102508

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *10/15/1918*
5. Place of death: *Home*
6. Cause of death: *Heart failure*
7. Signature of physician: *Dr. J. H. Smith*
8. Signature of registrar: *W. H. Jones*
9. Date of registration: *10/20/1918*
10. Place of registration: *City of New York*

9233

CERTIFICATE OF DEATH

Reg. Dist. No.

1
Page 4
after death.

How requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. From phase remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u> c. LENGTH OF STAY IN 1b <u>to the Lifetime</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kentland Memorial Hospital Ltd "Georgetown" R.R. 2</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chester town</u> d. STREET ADDRESS <u>"Georgetown" R.R. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>MARY</u> Last <u>JANE</u> <u>CHAMBERS</u> 4. DATE OF DEATH <u>August</u> Month <u>28</u> Day <u>1960</u> Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 5, 1875</u> 9. AGE (In years lost birthday) <u>84</u> yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food packer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Food processing</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard Henry</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>Yes</u> 17. INFORMANT <u>Vickers Chambers, R 2 Chester town Md</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>420.1</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-28</u> , 19 <u>60</u> , to <u>8-28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>D.O.A.</u> , 19 <u>60</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chester town, Md</u> DATE SIGNED <u>8-28-60</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. <u>Chester town, Md</u>		PHYSICIAN'S NAME (Type) <u>A.C. Dick, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Sept. 1, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Fairlee (col) Cem.</u> 22d. LOCATION (City, town, or county) (State) <u>Fairlee Kent Co. Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Valley</u> ADDRESS <u>Chester town, Md.</u> 24a. REC'D BY REGISTRAR <u>AUG 30 60</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Moore</u>	

CERTIFICATE OF DEATH

Reg. Dist. No. 09208

9234

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>				c. LENGTH OF STAY IN 1b <u>6 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent & Queen Anne Hosp</u>				e. STREET ADDRESS <u>Box 77 Trt. I</u>			
3. NAME OF DECEASED (Type or print) <u>James Emanuel Coleman</u>				4. DATE OF DEATH <u>August 2 1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-60</u>	9. AGE (In years last birthday) <u>0</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Chester, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Earl Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Hilda Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hosp. Records - Arch. Hall, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural causes</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis or ABO Incompatibility</u> DUE TO (c) <u>5 days</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month. Day. Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>8-2-60 3pm</u> 19 <u>60</u> , to <u>8-2-60</u> 19 <u>60</u> , that I last saw the deceased alive on <u>8-2-60</u> 19 <u>60</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry Paul Ross</u> M.D.				ADDRESS (Street, city or town, state) <u>203 N. Queen Street</u> DATE SIGNED <u>8-3-60</u>			
PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS</u>				LOCATION (City, town, or county) (State) <u>Chester, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>8-3-60</u>	<u>Shayton Cemetery</u>		<u>Rich Hill Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams - Chester, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>AUG 5 '60</u>		<u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072314XV4

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		COUNTY BALTIMORE	
DATE OF DEATH JAN 10 1918		TIME OF DEATH 10:00 AM	
NAME OF DECEASED JOHN J. HARRIS		SEX MALE	
AGE 45		RACE WHITE	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION LABORER	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
INTERVIEWED BY J. HARRIS		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESS J. HARRIS		SIGNATURE OF PHYSICIAN J. HARRIS	
SIGNATURE OF CLERK J. HARRIS		SIGNATURE OF REGISTRAR J. HARRIS	

RECEIVED JAN 10 1918

TO THE REGISTER OF DEATHS

FOR THE YEAR 1918

FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9241

CERTIFICATE OF DEATH

Reg. Dist. No.

09209

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. LENGTH OF STAY IN 1b 40 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharp Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last S. ETHEL..DOWNEY				4. DATE OF DEATH Month Day Year Aug. 24 1960			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3 1886		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Worton Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Bigelow				14. MOTHER'S MAIDEN NAME Anna Toulson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Clifton Downey Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive Heart Failure DUE TO (c) myocardial Disease							INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yrs 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14 , 19 59 , to 8/24 , 19 60 , that I last saw the deceased alive on 8/24/60 , 19 60 , and that death occurred at 3P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas J. Solon				ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 8/24/60			
PHYSICIAN'S NAME (Type) Thomas J. Solon				CHESTERTOWN, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26/60		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR DATE AUG 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

(M)

(1)

01509

CENTRAL & SOUTH

12841



DATE

TIME

TIME

10:00 AM

10:00 AM

DR. J. M. KELLEY

James E. Kelly

Worshipful Master

John G. Kelly

Worshipful Master

NOV

NOV

Worshipful Master

Worshipful Master

Worshipful Master

Worshipful Master

Worshipful Master

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Worshipful Master

CERTIFICATE OF DEATH

Reg. Dist. No.

09210

9235

1. PLACE OF DEATH o. COUNTY <u>Kent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. LENGTH OF STAY IN b. <u>4 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent & Queen County Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Edward Dwyer</u>				4. DATE OF DEATH Month Day Year <u>8 6 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/4/1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Edward Dwyer</u>				14. MOTHER'S MAIDEN NAME <u>Venabel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-5202</u>		17. INFORMANT <u>Daughter (EDITH BRICE LYNCH MD)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Bilateral</u> DUE TO <u>490X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rock Hall</u>	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/3/60</u> to <u>8/6/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/6/60</u> , 19 <u>60</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
21. ADDRESS (Street, city or town, state) <u>Wm. M. Gatewood M.D. Rock Hall Md.</u>				DATE SIGNED <u>8/6/60</u>			
21. ACTUAL SIGNATURE <u>Wm. M. Gatewood</u>				21. PHYSICIAN'S NAME (Type) <u>WM. M. GATEWOOD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cmty</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				23a. REC'D BY REGISTRAR <u>DATE AUG 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9236

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 115 College Avenue			d. STREET ADDRESS 115 College Avenue		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Alice First Nannie Middle Hague Last			4. DATE OF DEATH August Month 2 Day 19 Year 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory work		10b. KIND OF BUSINESS OR INDUSTRY PROD. PACKING		11. BIRTHPLACE (State or foreign country) Rock Hall, Md.	
13. FATHER'S NAME Joseph Richard Ryan			14. MOTHER'S MAIDEN NAME Margaret P. Berger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-9840		17. INFORMANT Maynard W. Hague, Chestertown, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Previously in good health, without any recent Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) physical complaints, without any history of cardio-vascular disease and without medical attention other than for respiratory illnesses, she arose & dressed as DUE TO usual & was found dead 7:20A.M. while on the toilet. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) usual & was found dead 7:20A.M. while on the toilet.					INTERVAL BETWEEN ONSET AND DEATH a few min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 2, 1960	
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF AUG. 4	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edward L. Kane		ADDRESS Church Hill		24a. REC'D BY REGISTRAR Aug 9 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kane

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0328

NAME OF DECEASED Joseph Richard Ryan		SEX Male	
AGE 18 years		RACE White	
PLACE OF BIRTH 115 College Avenue Boston, Mass.		OCCUPATION Factory work	
DATE OF DEATH August 2, 1960		TIME OF DEATH 7:10 A.M.	
PLACE OF DEATH 115 College Avenue Boston, Mass.		CAUSE OF DEATH Coronary Thrombosis	
MANNER OF DEATH Natural			
SIGNATURE OF PHYSICIAN Robert A. Ryan, M.D.			
SIGNATURE OF MEDICAL EXAMINER Robert A. Ryan, M.D.			



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9242

CERTIFICATE OF DEATH

09212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write FAIRLEE and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write LYNCH and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) STRONG NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MABLE R. JEWELL				4. DATE OF DEATH Month Day Year AUGUST 20 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 9, 1875	
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS RASIN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT Address JOHN R. JEWELL, KENNEDYVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Senility							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 11 , 19 55 , to Aug 20 , 19 60 , that I last saw the deceased alive on Aug 20 , 19 60 , and that death occurred on Aug 20 , 19 60 , from the causes and on the date stated above.							
ACTUAL SIGNATURE NORBERT C. MITSCH M.D.				ADDRESS (Street, city or town, state) Rock Hall, MD DATE SIGNED Aug 20/60			
PHYSICIAN'S NAME (Type) NORBERT C. MITSCH				Rock Hall, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/23/60		22c. NAME OF CEMETERY OR CREMATORY STILL POND CEMETERY		22d. LOCATION (City, town, or county) (State) STILL POND, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy ADDRESS STILL POND, MD.				24a. REC'D BY REGISTRAR DATE AUG 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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STILL NURSING HOME

DIABLE R. JAVELL

AUGUST 20

FEMALE WHITE

BOY 1972

HOUSEWIFE

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U.S.A

THOMAS RAY

UNKNOWN

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WOMB

JOHN K. JEWELL, KANSAS

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[Handwritten signature]

ROBERT G. JAVELL

STILL NURSING HOME

STILL NURSING HOME

STILL NURSING HOME

9237

CERTIFICATE OF DEATH

Reg. Dist. No.

09213

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>12 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u>			
3. NAME OF DECEASED (Type or print) First <u>Shelley</u> Middle <u>Ann</u> Last <u>Kelley</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-60</u>	9. AGE (In years last birthday) <u>0</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>12</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Spencer E. Kelley</u>				14. MOTHER'S MAIDEN NAME <u>Eileen Patricia Arnold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Spencer Kelley Millington Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>8-14</u> , 19 <u>60</u> , to <u>8-15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-15</u> , 19 <u>60</u> , and that death occurred at <u>10:27</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>8-15-60</u>							
ACTUAL SIGNATURE <u>A.C. Dick</u>		M.D. <u>—</u>					
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		<u>Chestertown, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 17, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Massey Cemetery</u>		22d. LOCATION (City, town, or county) <u>Massey, Kent Co;</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward S. Thomas</u> ADDRESS <u>Millington, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9238

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09214

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 1 life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		d. STREET ADDRESS 1 Cannon St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cannon St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle T. J. Last Keyser		4. DATE OF DEATH Month Aug. Day 18, Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1875
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist & Plumber		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Keyser		14. MOTHER'S MAIDEN NAME Emma Don't Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. not known	
17. INFORMANT Medford P. Keyser		Address Cannon St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED Arteriosclerosis (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 12, 1958 to July 26, 1960 , that (I) (we) last saw the deceased alive on July 26, 1960 and that death occurred at 7 A. M. from the causes and on the date stated above.			
22a. SIGNATURE Harry Paul Ross		22b. DATE SIGNED 8/19/60	
22c. PHYSICIAN'S NAME (Type) Harry Paul Ross		22d. ADDRESS Chestertown, Maryland Queen St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DATE AUG 22 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Wm. S. Hana	

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9239

CERTIFICATE OF DEATH

09215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown			
f. STREET ADDRESS RFD#2				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle Kent Last Lambert				4. DATE OF DEATH Month 8 Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/11/1883	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Motor Trans. unknown				10b. KIND OF BUSINESS OR INDUSTRY US Gov.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A..							
13. FATHER'S NAME George E. Lambert				14. MOTHER'S MAIDEN NAME Temperance Raleigh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes - Spanish Amer.				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Adelaide Lambert, wife, RFD#2, Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 450.0 DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) years DUE TO (c) years							INTERVAL BETWEEN ONSET AND DEATH 16 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-14-60 , 19____, to 8-14-60 , 19____, that I last saw the deceased alive on 8-14-60 , 19____, and that death occurred at 7:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry Paul Ross				ADDRESS (Street, city or town, state) 203 N. Queen St DATE SIGNED 8-15-60			
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS, MD				Chestertown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		22d. LOCATION (City, town, or county) (State) near - Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR AUG 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• *Journal of Management Education*

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[Faint, illegible text]

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 200 Calvert St.		e. STREET ADDRESS 1 200 Calvert St.	
3. NAME OF DECEASED (Type or print) First Robert Middle LeRoy Last Williams		4. DATE OF DEATH Month Aug. Day 15, Year 1960	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1960
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore T. Williams		14. MOTHER'S MAIDEN NAME Jacelyn Naomi Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jacelyn N. Williams		Address 200 Calvert St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Strangulation 9240.0 DUE TO (a) The baby had been perfectly well and was a very active child. It was put to bed about 10:00 A.M. When next seen at 12 Noon it had slipped through the bars on the side of the crib and was hanging by its head, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) seen at 12 Noon it had slipped through the bars on the side of the crib and was hanging by its head, DUE TO (c) seen at 12 Noon it had slipped through the bars on the side of the crib and was hanging by its head, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) which had caught in the space between two of the bars. It was INTERVAL BETWEEN ONSET AND DEATH short time			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) dead when found.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11:00 a. 8/15 1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chestertown Kent Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 8/16/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/60	
22c. NAME OF CEMETERY OR CREMATORY James Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Welby		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE Aug 18 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Kraus	

207218 3XV5

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1921

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF PHYSICIAN

NAME OF CORONER

NAME OF JURY

The body had been partially well and was a very active child. It was one of the best about 10:00 A.M. when next seen at 12 noon it had slipped through the bars on the side of the crib and was hanging by its head, which had caught in the space between two of the bars. It was found when found.

Chesapeake Rent Agency

Home

11:00-- 8:15

11:00-- 8:15

11:00-- 8:15

11:00-- 8:15

11:00-- 8:15

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Worton		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Worton (Coleman's Corner)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Coleman's Corner				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Hurlock		First John		Middle Hurlock		Last Wilson	
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 1909	
9. AGE (In years last birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Wilson		14. MOTHER'S MAIDEN NAME Annie W. Wilmer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 213-16-8532		17. INFORMANT Mrs. Margaret Wilson		Address Worton, RFD Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest from Emboli DUE TO (b) metastases from Lung DUE TO (c) Primary Carcinoma of the lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. radiation sickness from X-ray treatment of CA							
INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 weeks 8 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1953 to Aug 4 1960 that (I) (we) last saw the deceased alive on Aug 4 1960 , and that death occurred at 3 PM , from the causes and on the date stated above.							
22a. SIGNATURE Florence D. Joyce							
22b. DATE SIGNED Aug. 5, 1960							
22c. PHYSICIAN'S NAME (Type) Florence D. Joyce							
22d. ADDRESS RFD Worton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.		23d. LOCATION (City, town, or county) (State) RFD Worton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Berneth Walker				25a. REC'D BY REGISTRAR DATE AUG 8 '60		25b. REGISTRAR'S SIGNATURE C. L. H. H. H.	
ADDRESS Chestertown, Md.							

3243

CERTIFICATE OF DEATH

3243

Age 40 years

Age 40 years

Place of birth - Boston (Globe in corner)

Place of birth - Boston (Globe in corner)

Place of birth - Boston (Globe in corner)

Place of birth - Boston (Globe in corner)

Place of birth - Boston (Globe in corner)

Place of birth - Boston (Globe in corner)

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Place of birth - Boston (Globe in corner)